CHILD HEALTH FORMS & IMMUNIZATION RECORD

TO BE COMPLETED BY PARENT OR GUARDIAN

CHILD INFORMATION/RELEASE:

_____ _____ _____/ _____ / _____

CHILD'S NAME (LAST, FIRST) M.I DOB: MO DAY YEAR

_____ _____ _____ _____

CHILD'S ADDRESS CITY STATE ZIP

WE/I GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL HISTORY INFORMATION ON THE ABOVE CHILD TO: Casa dei Bambini.

(One Signature Required)

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____

PARENT/GUARDIAN SIGNATURE

PLEASE RETURN TO:

Casa dei Bambini
507 South Street
Bow, NH 03304
603.227.9300

casadeibambinicenter.com

This information will be held confidential and will be used only for the benefit of this child.

TO BE COMPLETED BY PHYSICIAN

CHILD HEALTH & MEDICAL HISTORY/INFORMATION:

A. Prenatal, Perinatal and Postnatal Development: Any significant findings that could influence this child's adaptations to a child care setting (i.e., physical handicap, sensory loss, developmental irregularities)?

_____

_____

B. Any chronic illness that may require medication, particularly observations or precautions in a child care setting (i.e., recurrent ear infections, seizure disorder, allergies)?

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_____

_____

C. Any hospitalizations, operations, or special tests of which a child provider should be aware of?

_____

_____

D. Pertinent family, social or health characteristics?

_____

_____

Immunizations for Child Care Agency Attendance
Parent may substitute a copy of child's immunization record.

Vaccine	Date	Date	Date	Date	Date	Date
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

Communicable Disease History **Recommended Screening/Testing**

Disease	Date of Diagnosis	Laboratory Confirmation	Physician		Date	Method	Result:
CHICKENPOX		N/A		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER				VISION			
				HEARING			
				SPEECH			
				HIB/HCT	N/A		
				URINE	N/A		
				LEAD	N/A		

TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER

HEALTH ASSESSMENT:

CHILD HEALTH & IMMUNIZATION RECORD FORM

PHYSICAL EXAM:

LENGTH/HEIGHT _____IN/CM %ILE_____	WEIGHT _____LB/KG %ILE_____	HEAD CIRCUMFERENCE _____IN/CM %ILE_____	BLOOD PRESSURE _____/_____

CHECK EACH LINE	NORMAL	AB-NORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK EACH LINE	NORMAL	AB-NORMAL	NEEDS FOLLOW-UP	NOT EXAMINED
SKIN /SCALP						CHEST, BREASTS			
NOSE, THROAT, MOUTH						EYE			
NUTRITION						HEART, LUNGS			
TEETH & GUMS						EARS			
NEUROLOGY & MUSCULAR						AB-DOMEN			
GLANDS INC. THYROID						SPEECH			
ORTHOPEDIC & SPINE						GENI-TALIA			

TEMPERAMENT:

EASY -GOING ____ AVERAGE ____ DIFFICULT ____

COMMENTS:

_____

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

_____

ASSESSMENT OF PHYSICAL DEVELOPMENT:

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A. ESTIMATE OF LEVEL OF MATURATION:

A. INFANCY (0-2 YEARS) EARLY: _____ MID: _____ LATE: _____

B. MID-PRESCHOOL (2-4 YEARS) EARLY: _____ MID: _____ LATE: _____

C. PRESCHOOL (4 YEARS) EARLY: _____ MID: _____ LATE: _____

D. SCHOOL-AGE (6-10 YEARS) EARLY: _____ MID: _____ LATE: _____

E. ADOLESCENT (11-18 YEARS) EARLY: _____ MID: _____ LATE: _____

COMMENTS:

_____

B. ESTIMATE OF FUNCTIONAL CAPACITY:

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS
GROSS MOTOR				
FINE MOTOR				
LANGUAGE SKILLS				
SOCIAL SKILLS				
EMOTIONAL				

_____ _____

PHYSICIAN'S SIGNATURE DATE OF EXAM

_____ _____

PHYSICIAN'S NAME - TYPED OR PRINTED TELEPHONE NUMBER

_____

DATE OF NEXT SCHEDULED EXAM